PROACTIVE
CHIROPRACTIC GROUP

X-RAY CONSENT

The doctor has explained that the purposes of the x-rays to be taken are to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-ray, I will be informed. I understand that I will then need to make the decision to seek additional advice from another health care provider for the "unusual finding". I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

CONSENT TO EVALUATE A MINOR CHILD (IF APPLICABLE)

☐ I, _____ (parent/legal guardian) of _____ (child's name) hereby grant permission for my child to receive chiropractic examinations and x-rays.

MALES: please skip to bottom of page and print/sign

FEMALES: (please pick the one that best applies)

PREGNANCY RELEASE

☐ I have been provided a full explanation of when I am most likely to become pregnant and to the best of my knowledge, I am NOT pregnant.

☐ By my signature I am acknowledging that the doctor or member of the staff has discussed with me the risks of ionization to an unborn child, and I have conveyed my understanding of the risks of being exposed to x-rays. After careful consideration I do hereby consent to have x-rays taken.

☐ I am pregnant, and therefore I am NOT getting x-rays

_____ _____

Print Patient Name **Date of Birth**

_____ _____

Patient Signature **Current Date**